FS 2011-01
CASE MANAGEMENT AND HOME AND COMMUNITY-BASED SERVICES (HCBS/FE)
Sections 3.1; 3.4; and 3.5

	SECTION			PAGE	STAKEHOLDER COMMENT	KDOA RESPONSE
1	3.1	8	B.5	8 of 14	*"or as otherwise required by KDOA"* - How will AAA case managers know if we are fulfilling the expectation of what is otherwise required? How about limiting this to state "as otherwise needed to meet HCBS FE customers' needs and/or related to policy or significant changes. We suggest basing this on customer needs either related to KDOA policy change and its impact or other significant change with impact on the customer.	Clarification has been made
2	3.1	8	B.5	8 of 14	"or as otherwise required by KDOA" redundant; bare minimum now in policy; thought it covered anything over that; don't have issue over it.	See #1
3	3.4	1	C	9 of 29 (+)	Term "direct support worker" should be consistent.	Changes have been made
4	3.4	1	C	7 of 29; 10 of 29	FSM states provide 12 hours max per day allowed for Attendant Care Services - with the time limit changes 12 hours does not seem possible. Should the max be changed to match the new CSW.	No change; 12 hours max per day remains the cap due to the opportunity for the CM to request additional time if needed to meet the customer's needs
5	3.4	1	E	15 - 16 of 29	Why is definition of Financial Management Services so detailed (e.g. I&A overlap)? Will cause issues in real world, e.g. for AAA - make sure only needs met; FMS perspective different. See lot of duplication in real world.	No change; FMS definition is detailed and must be consistent with the HCBS/FE waiver and provider manuals
6	3.4	1	E	15 of 29 (cont)	FMS - the I&A Function they will administer is directly related to SD R/R and their business processes. I'd like to see something that clarifies that boundary. FMS should not be paid when SD services are interrupted as their process is related to the SD work, which is also suspended during that time.	Clarification has been made
7	3.4	1	E	16 of 29	Define clearly what are administrative tasks under FMS.	See Sec. 3.5.9.B
8	3.4	1	E	16 of 29	*"I/A services may include activities that nominally overlap with provision of case management services . . ." Defining goals, needs, and resources Need clarity and definition on FMS role regarding human resource issues with chosen self direct workers, such as scheduling and other work performance issues. Identifying and accessing services, supports, and resources as they pertain to self directed activities Individual-centered planning Range and scope of customers' choices and options"* This is confusing and will cause confusion in the field as to what tasks are responsibilities of case managers and what tasks are FMS. Area Agency on Aging case managers assess, identify needs, establish goals with participants, discuss resources, review supports and develop plans of care based on this information and other observations. The case managers authorize services based on this assessment for each customer. Case managers would also educate on choices and options. FMS would focus on hiring, managing and other practical skill training for the self direct option.	See #6

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9	3.4	1	E	17 of 29	*"customer may want or need"* Remove "want" and include a statement indicating this is based on case manager professional determination. This way the FMS will contact the case manager directly to implement any needed changes on the plan of care and not the customer. The Area Agency on Aging case manager must be informed.	No change; bullet refers to I&A services provided under FMS and not to HCBS/FE services
10	3.4	1	F	20 of 29	Awesome service *(telehealth)* - used by VA; prior authorization? How does this relate to Wellness Monitoring? Should be parameters to restrict receiving both.	No change; will address in training
11	3.4	1	F	20 of 29	Home telehealth available in all settings, e.g. ALF? Support telehealth but reservations about not limiting it to a home (not an adult care home). Urge not to allow ALF/RHC/HP. May cause CMS backlash as they have been slow to accept ALF/RHC/HP as community-setting. Paying a lot of money in ALF without benefit - concerned about overall cost.	ALF/RHC/HP removed from housing option
12	3.4	1	F	20 of 29	Suggest adding bullets in paragraph that describes Customer Qualifications for this service to make it easier for CMs	Change has been made
13	3.4	1	F	20 of 29	With regards to the telehealth service: Page 20 of 29, 4th paragraph. Please consider setting some parameters on which clients could qualify or really benefit from this service. If you allow this to remain open to all clients any cost savings will most likely not be realized. There should be limits to either who can have it or limit assisted living/board and care homes from providing it. Facilities provide this type of service now as part of the care package.	ALF/RHC/HP removed from housing option
14	3.4	1	F	20 of 29	Can customer also receive wellness monitoring?	Yes
15	3.4	1	F	20 of 29	We unequivocally state that "setting" be a prime consideration in the parameters that define this service. For example, it is a duplication of what is provided in setting where facility care employees are available 24 hours. This service in this setting duplicates because the nature of this service setting is that staff is available. To allow such a provider to bill for wellness and telehealth a duplication of service and would unwisely use taxpayer dollars to benefit a certain group of providers. *(sic)*	ALF/RHC/HP removed from housing option
16	3.4	1	F	20 of 29	What is the approval process for this service? Currently approvals are not being provided timely for routine changes to plans of care (pocs). How are Area Agencies on Aging and KDOA going to address this by September 1, 2011?	Approval process is same as for other HCBS/FE services; AAAs and KDOA will need to follow the timeline provided during training to ensure Sept. 1 implementation is met
17	3.4	1	F	20 of 29	We support telehealth service when it is provided in a setting where an individual is living in a home or apartment that is independent from a facility setting that offers staff attendants close by as part of the facility's service array.	ALF/RHC/HP removed from housing option
18	3.4	1	F	20 of 29	Approval turnaround time for this service is important and we are concerned about this given current approval process and lag time.	See #16
19	3.4	1	F	20 of 29	We see telehealth as a good means to prevent pre-mature placement in a hospital, assisted living or nursing home facility.	Thank you
20	3.4	1	F	20 of 29	We suggest that a monthly report be sent to case manager and physician similar to a wellness report. This would be a proactive way to address the management of chronic health conditions.	Already included in "Limitations"

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21	3.4	1	F	20 of 29	What is the process of checking to verify that telehealth has been approved through another funding source?	KDOA will ensure this service is not being provided under another Medicaid program; CMs need to ensure the service isn't available under another funding source
22	3.4	2		29 of 29	Other: Telehealth is a great product. However, our budget being what it is, this should not be added at this time. If it is added, I hope the reimbursement rate is lessened to be more in line with other current Unit Rates.	No change; telehealth is a separately funded service and does not affect rates for other HCBS/FE services
23	3.4	2		29 of 29	TBA unit rates for ATCRUD, COMPUD and FMS. I hope the workers actually doing the work for customers are compensated for their work by this rate and that the administrative FMS fee isn't disproportionate.	KDOA agrees
24	3.5	5	A.3	7 of 34	May be difficult for the CM to determine who is living in the home. If caregiver is living in the home and knows policy is coming and moves out, then can we pay them? Would be consistent if at re-assessment; if someone moves out, adjust the timeline or something . . .	No change; training issue
25	3.5	5	A.3	7 of 34	Grandfather in the policy change?	No change; policy implementation is linked to the effective date of the CMS waiver amendment.
26	3.5	5	A.3	7 of 34	Regarding reduction in overall services - has KDOA thought of overall cost increase for customers moving into nursing homes?	Yes, this was taken into consideration; however, there is a process to request additional time to meet the customer's needs, thereby avoiding nursing home placement
27	3.5	5	A.4	7 of 34	If daughter has been doing shopping, cleaning, must she continue if burned out? Rigid. All services are informal when CM does initial assessment. If daughter no longer doing informal support, then can services be provided? Open to lots of interpretations.	Clarification has been made; agency services may be provided if lack of informal support is documented in the customer's case file
28	3.5	5	A.4	7 of 34	In some cases the person providing informal supports is overwhelmed so how can we expect them to continue under these circumstances? If they refuse due to caregiver stress or being overwhelmed what is the consequence?	See #27
29	3.5	5	A.4	7 of 34	This is good for putting a stop to the daughter that is currently and has been for years coming to moms' house to vacuum and do a weekly load of laundry and has done so informally - but wants to be paid after learning from her friend that she could be paid to do these tasks. We understand where this is coming from. Our concern is that the policy should be written in such a way as to allow for caregiver relief. This relief can be having a home health agency come into the home to provide the laundry or vacuuming thereby providing caregiver support and respite. We encourage language such as in number #3 that states if the informal support is unable or unwilling to perform these tasks then they can be provided formally by a home health or non-self direct provider. This would prevent the daughter from saying that she can't be paid but the daughter (the customer's granddaughter) could be paid.	See #27

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30	3.5	5	A.4	7 of 34	As no customer will be grandfathered in we certainly anticipate that much TCM and supervisory time will be used to address unhappy customers and handle appeals. For this reason, we urge that consideration be given to grandfathering or some kind of tiered implementation of these new rules.	No change; policy implementation is linked to the effective date of the CMS waiver amendment.
31	3.5	5	A.4	7 of 34	We need to consider cultural and language barriers in these draft changes; i.e., we have diverse populations with some older people not speaking English-- they only receive care from their families due to cultural and language barriers and many generations live within the same household. This is a comment to remind us to be culturally sensitive as changes are written in this policy.	No change
32	3.5	5	A.4	7 of 34	Customers at the year point with Money Follows the Person--will they continue with "old" services or will their service at time of one year in the community change to become "regular HCBS FE"? And will the MFP customer be submitted to the HCBS-FE expectations? Area Agencies on Aging more need time to process how these proposed changes will affect transition work from nursing home to home. We need an opportunity to speak with KDOA MFP directing staff to see how change will impact the implementation of MFP services.	MFP mirrors HCBS/FE services; these customers will go through the same process of CSW review
33	3.5	5	B	8 of 34	We also believe it is important to have the case manager be required to review the facility's Health Service Plan.	Health Service Plan is component of Negotiated Services Agreement
34	3.5	5	B.4	8 of 34	We urge language to allow that time studies be requested as needed and at the discretion of the case manager and supervisory staff. Time studies can be useful and very helpful tools when working with ASLG settings.	No change; CM may request time study if needed
35	3.5	7		16 of 34	Interruption of services - FMS provider still collecting fee if customer is in the hospital? If self-direct is on hold, what services are being provided?	Due to a monthly rate and possible lag time for the various processes (time sheets, payroll taxes, etc.) activity could still occur while customer is hospitalized
36	3.5	9	B	19 of 34	Who or what agency is doing the oversight for 3.5.9B?	KDOA, SRS, HP, and KHPA will provide oversight
37	3.5	9	C.1.c	22 of 34	Term "worker" needs to be changed to "direct support worker"	Change has been made
38	3.5	#		25 of 34	Does not address when a case has been closed. Refer to HIPAA. KAMIS manual still refers to PSAs.	Change has been made
39	3.5			Overall	Approval process (3 day and 7 day) still seems reasonable.	Thank you
40	3.5		Appx I		Are reasons for additional time meant to be an exhaustive list or examples of acceptable reasons?	Clarification has been made
41	3.5		Appx I		With reduction in services, negotiated fees will be adjusted and people will be forced into nursing homes. ALFs will increase rates to take advantage; will anticipate POCs reducing and will increase rents	Recommend contacting the LTC Ombudsman, LTC complaint line, or Krista with specific complaints

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42	3.5		Appx I	Overall	Appreciate maximum time limits; concerned CMs will always use max time instead of actual.	Policy requires CMs to base services on needs; if it becomes apparent that maximum time limits are consistently used, additional policy changes will be made to ensure compliance and maintain cost efficiency
43	3.5		Appx I		If a set number of self-direct hours were established there would be less pressure on the TCM to compensate the family or write large POC for assisted living/home plus providers. I don't think the State should be expected to carry the burden of high dollar POC's at a home-plus when other housing options are available.	No change; expectation is that no matter what the living environment is, the POC is developed based on the customer's needs.
44	3.5		Appx I	Overall	Although we support consistency and cost control measures, we do have serious concerns about the rigid quality placed on specific activities and services that frail elders need to remain at home and the unintended consequences that implementing these proposed changes may have on older Kansans, family caregivers and the service infrastructure.	The impact of these policy changes will be monitored; also, there is a process to request additional time to meet the customer's needs
45	3.5		Appx I	Overall	Since there will not be any grandfathering in making the changes on the self-direct and CSW time limit changes - if it will put the customer in the NF will this be a consideration for exception?	No change; there is a process to request additional time to meet the customer's needs, thereby avoiding nursing home placement
46	3.5		Appx I	Overall	We believe there should be allowances for Area Agency on Aging case manager discretion regarding physical impairment as well as cognition impairments as reasons for additional time.	No change; KDOA will make the final determination on requests for additional hours
47	3.5		Appx I	Overall	Too much rigidity or limitation in allowable time for "transfer" "bathing" and other essential tasks in the typical home setting where the customer is supported by an unpaid caregiver, may affect the number and availability of providers - especially those who must travel large distances to provide care.	
48	3.5		Appx I	Overall	Case managers will have to write frugal and inflexible plans of care that may not provide adequate service for frail elders if service plans are interpreted rigidly.	CMs need to write POCs based on customer's needs; there is a process to request additional time if needed to meet the customer's needs
49	3.5		Appx I	Overall	If limits are in place by 9/1/11, will service limits be applicable if the customer is coming from a nursing home?	Yes
50	3.5		Appx I		Bathing/grooming additional time limits - add stroke as acceptable reason for additional time (e.g. bed bath)	Change has been made
51	3.5		Appx I		Not sure maximum time (30 minutes) for shower, oral hygiene, and skin care is doable.	No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs
52	3.5		Appx I		Bathing/Grooming: Please add to "Reasons for Additional Time" Physical Disability, temporary or permanent, resulting in inability to perform tasks (i.e. stroke, arthritis, amputation, injury, surgical recovery, pain)	See #50; no other changes made

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53	3.5		Appx I		Bathing/Grooming - add amputee, add chemotherapy treatment	No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs
54	3.5		Appx I		Bathing/Grooming: Time needs to be specified as to number of days per week. The way it is worded lends the TCM to believe that 6 days per week is ok since exceptions are 7 days; Sponge baths should be a reason for more time	Clarification has been made
55	3.5		Appx I		Bathing/Grooming: We suggest that 30 min for bathing and grooming skin care, hair care and oral hygiene is not enough time for the maximum.	No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs
56	3.5		Appx I		Many showers last longer than the allotted 30 minute maximum.	No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs
57	3.5		Appx I		Dressing/Undressing: Increase to max. 30 min. twice daily. Add same items as in Bathing/Grooming.	No change to time but have added stroke with physical limitations
58	3.5		Appx I		Dressing/Undressing- add chemotherapy treatment	No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs
59	3.5		Appx I		Dressing: Will there be additional time allowed for consumers with very little mobility or paralyzed?	See #57
60	3.5		Appx I		Time for putting on shoes for residents with prostheses is not adequate.	No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs
61	3.5		Appx I		Dressing/undressing due to incontinence mishaps could exceed twice a day limit.	Policy will allow for more than twice daily
62	3.5		Appx I		Toileting: Do not exclude waiting time for resident who needs constant supervision. Do not exclude sleeping time in "Reasons for Additional Time". Add "To include sleeping time if care needs require". Toileting is required at night if resident is incontinent to avoid skin breakdown.	1) No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs; 2) clarification made for sleeping time
63	3.5		Appx I		Toileting- add chemotherapy treatment	No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs

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64	3.5		Appx I		What is manageable incontinence? Who defines it?	"Incontinence Management" is referenced in policy; definition is referring to supervision/assistance with incontinence episodes
65	3.5		Appx I		Waiting time while toileting should be allowed.	No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs
66	3.5		Appx I		Mobility: 30 minute maximum per day is not adequate even for meals if this includes transfers. Please increase to 60 minutes max per day to include activities, toileting, bathing. Alternatively, add "requires physical assistance" to Reasons for Additional Time.	No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs
67	3.5		Appx I		Mobility (transfer/walking in home)-add amputee, add chemotherapy treatment. Take range of motion out of the norm. Range of motion should be exception only on customers that are bed bound/score 4 on ADLs. (this is abused as exercise, when ROM is truly for folks to prevent contracture).	Proposed policy lists ROM exercises under exceptions; no change
68	3.5		Appx I		Mobility: 1 hour a day due to many clients need assistance getting out of chairs/off the toilet even though they have equipment due to fall risk or unsteadiness. If there are range of motion exercises that are prescribed by the doctor or therapist more time should be allowed.	No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs
69	3.5		Appx I		Longer eating time required for reasons other than cognitive impairment, e.g. for strokes, choking risk, customer eats extremely slow; DSW may need to stay with customer if choking risk	Change has been made for stroke and choking risk
70	3.5		Appx I		Eating: OK	Thank you
71	3.5		Appx I		Eating -add monitoring intake for cognitively impaired customers and add severe physical impairment e.g. CVA w/ paralysis or Parkinson's that require assistance.	See #69
72	3.5		Appx I		Eating: Time allowed is not adequate for tube feeding, choke risks, or total feeding.	See #69
73	3.5		Appx I		Eating with supervision: Our concern is that supervision is needed for certain situations, for example, supervision for stroke victims who are at risk of choking.	See #69
74	3.5		Appx I		Tube feeding? Our concern specific to Assisted Living settings is about the NSA fee increasing due to a decrease in authorized HCBS time. Can the family choose to pay the NSA fee, if it becomes more than the customer can pay?	No; Medicaid providers sign agreement to accept HCBS policies and cannot supplement services through the customer/family
75	3.5		Appx I		The 15 minutes allowed for tube-feeding doesn't allow adequate time for flushing the tube afterwards? Extra time is needed for that.	No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs

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76	3.5		Appx I		How to divide meal prep between multiple customers, e.g. spouse in the home? How to divide in ALF? Congregate setting - how to decide what's appropriate? Try to compromise in group setting.	Clarification has been made; KDOA will address during training sessions with CMs
77	3.5		Appx I		Meal Preparation - Add Specialized Diet or Consistency Change to "Reasons for Additional Time" with max of 10 hrs./week.	No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs
78	3.5		Appx I		Meal Prep (breakfast, lunch, supper and snack) - clarify that 2 HCBS customers' within the same home meal time should be divided and any/all meals prepared shared in the same home. ALF is a separate apt so that is not impacted division rule. (no exceptions)	Clarification has been made; KDOA will address during training sessions with CMs
79	3.5		Appx I		Meal Preparation: Needs to be more specific to determine the amount of time that should be allowed if the consumer is receiving HMEL. TCM's would need to clarify on CSW if HMELs are delivered 5 days per week or 7.	No change; KDOA will address during training session with CMs
80	3.5		Appx I		Meal preparation: Is facility setting divided among the number of HCBS-FE customers also residing in the setting? For example let's take a situation where out of 20 beds six of them are HCBS. Do we divide the time by six HCBS customers being served at the same meal? If two of these are diabetics, do we divide the time by two for preparing the same diabetic diet meal? Is this the same for non-facility in home settings? Divide the meal time by the number of people eating the same prepared meal? More consideration and clarity is needed. Clarity in this area is also needed for those customers who are to eat five small meals a day and for those who have five-six tube feedings a day.	No change; KDOA will address during training session with CMs
81	3.5		Appx I		At one particular AL setting, they will lose reimbursement for over a half FTE just for reduced meal prep time alone. And that's with only 7 residents.	No change
82	3.5		Appx I		Shopping - divide if spouse is also on HCBS? Save on Meal Prep too?	Clarification has been made
83	3.5		Appx I		Request clarification on shopping - if spouse is living in the home, we only allow 30 minutes?	See #82
84	3.5		Appx I		Shopping: OK	Thank you
85	3.5		Appx I		Shopping (no exceptions)	Thank you
86	3.5		Appx I		Shopping: Allow for additional time due to geographic location of consumer & stores	No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs
87	3.5		Appx I		Two hours a week allowed shopping time is inadequate.	No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs

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88	3.5		Appx I		Regarding Money Management, DSWs will buy money orders, provide other services for customers that don't have bank accounts. Some customers dependent on this service. Some customers may be blind or otherwise dependent on this service. In rural areas, may need this help, e.g. reading mail, paying bills.	No change; this service should be provided as an informal support; CMs should identify individuals/organizations to provide this service
89	3.5		Appx I		Money Management - Add max of 30 min./week to account for resident payee/bill pay/banking activities.	See #88
90	3.5		Appx I		Money Management (informal only at present draft) make exception for blind customers only.	See #88
91	3.5		Appx I		Money Management: We request exception language in this area for those people that do not have informal supports. Or in situations where no payees are available in the area due to isolation/rural setting.	See #88
92	3.5		Appx I		Under Accompany to Medical Appointments, other possible medical treatments that a client might have to travel to and need the accompaniment include chemo therapy treatments, wound care center, and physical therapy.	Clarification has been made; reason for accompaniment does not relate to medical treatment; must be cognitive or mobility issue
93	3.5		Appx I		Accompanying to Medical Appointments: Expand "Reasons for Additional Time" to include "when medical condition warrants" (such as physical disability, anxiety, transport to/from hospital or ER)	See #92
94	3.5		Appx I		Accompanying to Medical Appointments -add chemotherapy, wound care, physical therapy	See #92
95	3.5		Appx I		Accompanying to Medical appts - Please consider certain diagnosis besides dialysis treatment such as cancer treatment and other treatments/appts when customer is so frail and due to diagnosis. They may be very cognitive but very frail.	See #92
96	3.5		Appx I		Time should be allowed for accompanying residents to medical appointments when family isn't available to do so.	See #92
97	3.5		Appx I		Telephone Usage: Allow max. 30 min/week to account for making medical appts, use of multi-media.	No change; reflects current policy
98	3.5		Appx I		Laundry/housekeeping need to be combined; often doing both at the same time. Also, need 4 hours minimum per week.	Change has been made
99	3.5		Appx I		May want to consider for laundry and cleaning to keep them separated as independent activities but perhaps change the proposed maximum from 1 hour each to 1.5 hours each.	See #98
100	3.5		Appx I		Laundry: OK	See #98
101	3.5		Appx I		Laundry -change time max to 2 per week	See #98
102	3.5		Appx I		Laundry: 1 1/2 hours is more accurate-would allow for washing, drying, folding, and hanging clothes up.	See #98
103	3.5		Appx I		One hour a week for laundry is not adequate. An hour and a half is more reasonable.	See #98

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104	3.5		Appx I		Laundry and Housekeeping: We suggest maximum of 4 hours weekly. Keep these services combined to allow for flexibility.	Change has been made
105	3.5		Appx I		Insufficient time provided for laundry; should be at least 2 hours. Laundry should be combined with housekeeping. If doing meal prep, need more than 1 hour for housekeeping if it includes clean-up. Need 2 hours for laundry and 2 hours for housekeeping.	Change has been made
106	3.5		Appx I		Housekeeping: Add "Reasons for Additional Time: if resident is incontinent of bowel and/or bladder to max of 1 hour/day. (trash removal, carpet or floor cleaning, toilet cleaning)	See #98
107	3.5		Appx I		Housekeeping (no exceptions)- Change time max to 2 per week - consider Hoarding issue/APS involvement for limited exception.	See #98
108	3.5		Appx I		Housekeeping: As a HHA for 6 years I know that it took an average of 2 hours per week to clean a consumer's house (and that is constantly hustling). This included vacuuming, mopping, taking out trash, changing linens AND cleaning the bedroom, bathroom, kitchen and living room. Workers could not complete tasks in 1 hour and this could create health and safety issues.	Change has been made
109	3.5		Appx I		Management of Medications/Treatments open to ALF? Sounds like a lot of time for this service; only need 2 to 2 1/2 hours/week.	No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs
110	3.5		Appx I		May need more time for Management of Medications/Treatments if customer has cognitive issues - may be resistive to help.	No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs
111	3.5		Appx I		Management of Medications/Treatments: 3.5 hr/week is adequate for Oversight, Cuing and Medication Set-up only, but need at least 1 hr/day to account for medication administration, Medication Regimen Review, Lab follow-up, physician orders, crushing of meds, documentation.	No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs
112	3.5		Appx I		Medication management - This is the reason why some customers are in the AL for this needed service and it is given 8-12+ times a day. This does not seem like enough time per week for this tasks. If they are taking breathing treatments it is not enough time for that besides medication admin.	No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs
113	3.5		Appx I		Under Management of Meds/treatments it needs to include Administration, as well as Oversight/Cueing and medication set up.	No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs
114	3.5		Appx I		For Money Follows the Person (MFP), will the customer have the same limitations after the first year of MFP as it may influence customer's decision on whether or not to participate.	See #32
115	3.5		Appx I	MFP	We also would like to request additional information from Deb Schwarz, MFP and how these proposed time allowances would impact MFP consumers.	See #32
116	3.5		Appx I		Approval process for exceptions - should have name other than Cost Cap Exception to avoid confusion.	KDOA agrees

	SECTION			PAGE	STAKEHOLDER COMMENT	KDOA RESPONSE
117	3.5		Appx I		Cost Caps: If CMS requires CSW Cap Approval at KDOA level, dissolve current Cost Cap Process and insert CSW Cap Approval Process in its place. Any CSW area over the maximum would be submitted via KAMIS process with 7 working days processing time.	Process will be covered in training
118	3.5		Appx I		If the time limit exception request will be approved at the AAA level (CM supervisors) how will this apply to private CME where there are no supervisors?	Approval for time limit exceptions will be a KDOA function
119	3.5		Appx I		Any thoughts to allowing clients comp for fees? Clients may be forced off program.	See #74
120	3.5		Appx I		If family expects additional time, can family supplement?	No; see #74
121	3.5		Appx I		Can family supplement hours through private pay if denied exception to additional hours on HCBS/FE waiver? How is the process going to work for the approval of the additional hours?	No; see #74
122				CSW Form	Don't want limits in hands of providers; will write POCs based on need - will see times creeping up to max allowed. KDOA needs agreement among CMs that they will not provide this document to providers but enforcement is problem. CM needs to educate consumer - likes it combined. Need 1-page reference sheet rather than included on CSW.	KDOA will provide a 1-page reference sheet and remove from CSW
123				CSW Form	Delete the “maximum times allowed-reasons for additional time column.	See #122
124				CSW Form	In order to allow for cost controls, the maximum numbers of hours should not be on the customer service worksheet that is shared with family and providers; however, we believe in order to accomplish this, there would have to be written agreements among all case management entities not to share these documents or provide this information by other means. We believe this would be impossible to enforce. ***(Alternative suggestion: see below)***	See #122
125				Overall	(NOTE: See comment above) ***Alternative suggestion:*** Put a cap on a "normal service plan." Let's assume that most customers can be taken care of in a home-based setting each month for $2,280 which is 60% of NH cost. The case manager would develop a plan with participation of the customer, informal supports and the community network available for the customer. Case managers would be allowed discretion to "use" the $2,280 - and in most cases less - to meet the individual needs of the customer with full participation of the customer in the development of this plan. This would be similar to what we do now with one exception: **require that plans over the set limit must meet specific criteria to be considered for a cost cap exception.** This would allow creativity between the customer and the cm to meet care needs within a firm cost.	No change; this policy is being implemented statewide to increase CM consistency and reduce pressure on CMs to increase services and budget
126				CSW Form	Will every Customer Service Worksheet (CSW) be sent through KDOA to prevent duplication? Bathing through home health versus Medicaid?	Will depend on CMs to ensure no duplication; hospice and home telehealth continue as is
127				CSW Form	Have CSW worksheet in Excel? CM works with customer but needs official document for customer signature (without max time limits). Can hide column in spreadsheet and print. Leave it - actual UAI won't have anything on it.	See #122

	SECTION			PAGE	STAKEHOLDER COMMENT	KDOA RESPONSE
128				CSW Form	Add customer's name to each page; change margins for approval process; use as a turnaround document for approval.	1) Change has been made; 2) no change; 3) no change
129				CSW Form	Please consider removing the maximum amounts allowed for each section off of the CSW. Perhaps consider making a one page reference sheet that we can take with us on assessments that define these parameters (CARE Program has something similar). Leaving it on will cause confusion for the clients and the providers.	See #122
130				CSW Form	CSW Modifications: On the CSW, we need to have "informal only" in Mobility Supervision. On the CSW, we need to specify no administrative tasks allowed e.g. documenting they gave a pill or ordering meds etc. Have more space under Bathing/Grooming, Dressing to require specifics on what tasks are being done and the time allotted.	1) Change made; 2) no change; 3) change made
131				CSW Form	CSW- Toileting - is there a max number of times for toileting per day. Many customers are on diuretics and go to the bathroom often throughout the day.	No change; times were established based on workgroup consensus; there is a process to request additional time if needed to meet the customer's needs
132				UAI Form	With regards to the revised CSW(rolling transfers/walking into the new mobility category) please consider making the same change to the UAI both in paper and KAMIS forms so there is consistency with the forms. This will assist case managers in being more efficient and less confusion with which score to use for the mobility section. Example: I do UAI scoring and a client has a 3 for transfers but a 2 for walking, which level of impairment do we put then on the mobility section of the CSW? Do we use the 2 or use the higher level and use the 3? Leaving it without changes may cause confusion also in the QR process when they cross match our UAIs with the CSW and with KAMIS.	CSW Form will be altered to accommodate listing UAI score for both tasks
133				UAI Form	Also with regards to the CSW change in the area of what is now known as transportation- please consider changing the UAI (kamis and paper) to match the new term of medical accompaniment. This speaks to a consistency issue again.	No change due to industry standard of IADL terms
134	3.5			Overall	It was said implementation will be Sept 1, 2011. What kind of time frame will case managers be given to adjust all plans of care reflecting the new CSW time limits and self direct changes etc? Will it be the next annual or will it all need to be done by a certain date?	Process will be covered in training
135	3.5			Overall	Please allow the full quarter of July 1, August, September 30 for implementation. If it's a firm 9/1 start, TCM's would have to see all clients/responsible party 7/1/2011-8/19/2011 in order for a Timely NOA to be sent out. So far, we will be seeing 99% of clients regarding Cost Savings and FMS.	No change; policy implementation coordinated with HCBS/FE waiver amendment
136				Overall	The Web Training/Conference Call on these Cost Savings cutbacks is June 16, Thursday 130-330. We really hope this is available on line for staff unable to attend this training or there is one more training set.	Multiple trainings will be scheduled
137				Overall	We request additional time be granted for the submission of comments. Sufficient time was not allowed for case managers to receive process and respond with their comments.	No change due to tight timeline and CMS waiver approval requirements

	SECTION			PAGE	STAKEHOLDER COMMENT	KDOA RESPONSE
138				Overall	Although we support KDOA's position in this tough budget year and laud the efforts of KDOA Secretary Sullivan in his commitment to in-home service options for frail seniors, the turn-around time for review and comment on these important HCFE changes does not allow for full discussion of the consequences and full impact of these measures in the lives of frail elders, caregivers and providers. We request until May 17th at 5 p.m. - three additional working days - for KDOA to accept comments and questions.	No change due to tight timeline and CMS waiver approval requirements
139				Overall	HCBS revenues were $850 less for waiver residents versus private pay residents.	No change
140				Overall	From our experience, HCBS FE services in Assisted Living facilities are not an easy fit. It is not easy for an Area Agency on Aging case manager to write a plan of care for someone in a facility due to the complexity of this setting. Plans of care are generally higher because of there are few unpaid caregivers in these settings and there are real pressures to write higher plans of care in these settings.	No change; expectation is that no matter what the living environment is, the POC is developed based on the customer's needs.
141				Overall	When unpaid family caregivers do not get the supports needed to keep caring for their loved ones in those settings beyond the doorways of facilities, they grow tired and decide that a facility option is the best choice. Kansas leaders can expect more seniors entering facilities - and higher Medicaid costs.	See #27
142				Overall	Area Agency on Aging Case Managers are not beholden to any provider organization. We have a long-standing and proven record of addressing seniors in-home service needs, while, at the enlisting support *(sic)* of unpaid caregivers in non-facility home settings and, at the same time, keeping watch on the cost to taxpayers on each plan of care. There is not any incentive for us not to do "gate-keeping." This is not the case for every provider of HCBS TCM who have incentives to write higher plans of care because their business model depends on gaining and keeping clients.	See #140
143				Overall	We believe waiting lists for the HCBS FE waiver should be avoided - but not avoided at all costs. It is poor and short-sighted public policy to implement proposed measures for HCBS waiver that will adversely affect - or even harm - seniors who rely on support from unpaid family caregivers in order to remain at home and away from the doorways of more expensive facilities.	No change; there is a process to request additional time to meet the customer's needs, thereby avoiding nursing home placement; CM training will be provided
144	3.5		Appx I		Technology to manage time recording at each AL home visit may be unaffordable.	This is outside the scope of the proposed policy update and will be considered at a future time; the new electronic system will be incurred by the state and not the provider.
145				OTHER	We would like clarification needed on electronic care tracking device: is it mobile? Many services might also be provided in the common areas. Will the home have access to the same information from the electronic system when it is forwarded to the state?	This is outside the scope of the proposed policy update and will be considered at a future time; the new electronic system will be incurred by the state and not the provider.

	SECTION			PAGE	STAKEHOLDER COMMENT	KDOA RESPONSE
COMMENTS RECEIVED AFTER DEADLINE:						
				Overall	My objections to these changes are ; The limitation caps being established the same for Self Directed Care as Provider Directed Care is not justified or addressed in the rational for change. What we have is a " fundamental fairness" issue. The question: Are the importance of the State's interest being served and the appropriateness of the State's method of implementation against the resulting infringement of individual rights both customer and providers being evaluated. 1) No rational is given for limitations to providers/customers for ADL and IADL services. 2) No economic impact statement has been made. 3) No rationale for comment period of only 3 days. 4) No rational is given on KDOA requests for additional customer contacts. 5) No rational given for implementation of June 1, 2011.	
				Overall	6) Impact of Money Follows The Person which is a facility (Provider-Directed only) program; Aging in place concept must be a common practice in the facility, therefore a resident contract may not be terminated due to declining health or increased care needs.	
				Overall	Medicaid services may be increased to meet the needs through the MFP POC process. (K.A.R. 26-39-102 Admission, Transfer, and Discharge, 26-41-200 Resident Criteria)" Policy Issue: Revision to the HCBS/FE Waiver adds Home Telehealth and Financial Management Services (FMS) as waiver services. Rates for self-directed Attendant Care Services and Comprehensive Support are reduced to reflect the separation of FMS from these services. TCM customer contact requirements have been revised to include KDOA requests for additional customer contacts.. Time limitations have been added to Attendant Care ADL and IADL services; restrictions have been placed on formal IADL services if there are other individuals living in the home in which the customer resides; and a requirement for continuation of informal supports has been added. *(Continued . . .)*	
				Overall	Rationale for Change: Home telehealth is being added as a waiver service due to funding provided for this purpose during the 2011 legislative session. CMS is requiring the state to unbundle Financial Management Services for customers who choose to self-direct their care and rates for self-directed services are being adjusted accordingly. Provisions are being added to allow for additional TCM customer contacts based on KDOA requests. Time limitations are being established for ADL and IADL services. Restrictions are being added that will prevent an individual living in the same home as the customer from being paid to provide certain IADL services. A requirement for continuation of informal supports the customer has been receiving prior to the development of the Plan of Care is being added to enhance program efficiencies. *(Continued . . .)*	

	SECTION			PAGE	STAKEHOLDER COMMENT	KDOA RESPONSE
				Overall	The existing cost caps were approved and published 7-2010 effective 8-2010 as follow; 3.5.6 Cost Cap Exceptions The monthly cost cap amounts for HCBS/FE services are as follows: Level I is $1,965; Level II is between $1,965.01 and $3,999.99; Level III is $4,000.00 and over. What is the rational for the change? KDOA 2010 Annual report states; During SFY 2010, the average monthly Medicaid payment for a resident in a nursing facility was $2,861. During the same time, the average monthly Medicaid payment for a person served by the Home and Community-Based Services-Frail Elderly (HCBS-FE) waiver program was $1,067. The potential overall savings from those individuals who were diverted from more costly nursing facility care for an entire year is approximately $31.5 million *(Continued . . .)*	
				Overall	State Licensed Facilities State regulations assure that residents receive care that meets accepted standards. However, none of the state requirements are considered in the reimbursement rate for Provider Directed Care.	
				Overall	It is not logical, justified and no rational has been given to establish limitation caps (Appendix I) the same for Self Directed Care as Provider Directed Care as Self Direct Care does not own the same issues related to aging in place. Additionally, the importance of the State's interest and the appropriateness of the State's method of implementation weighted against the resulting infringement of individual rights of providers and customers have not been evaluated in regard to Provider-Directed Care.	